

reduced to five by day four. Of note, the COWs scale increased to 10 by day seven on 0mg of buprenorphine and naloxone.

Conclusion: Kratom possesses properties that can be successfully used as an alternative to heroin use. Nonetheless, there is a potential for abuse, which results in severe opioid-like withdrawal symptoms when the user attempts abstinence. Patients require increasing amounts of kratom as they develop tolerance. Kratom withdrawal symptoms can be successfully managed with opioid detox protocol or buprenorphine/naloxone protocol over a period of five days, although symptoms noticeably last longer. Pharmaceutical companies should explore safe, physician-guided administration of kratom to reduce heroin use and add to our repertoire of methadone or buprenorphine in managing opioid use disorders.

Acknowledgment: I would like to thank Dilys Ngu, MD, for her help in review of this report and the CMSRU – AtlantiCare track for their support.

10 A Case Report and Postulated Systematic Approach to the Evaluation of Emotionalism Post Stroke in a Crisis Unit

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Introduction: Emotionalism post stroke, when inadequately addressed, can cause distress to patients including embarrassment, confusion, possible caregiver complaints, and an overall decrease in health-related quality of life (Badhan, et al, 2014). Also known as pathological laughing and crying (PLC), emotionalism post stroke refers to the involuntary and neurologic pseudo-bulbar affect (PBA). It often leads to uncontrolled and exaggerated expressions of inappropriate, emotionally charged outbursts such as laughing and/or crying (Parvizi, et al, 2001). This “emotional lability” is usually seen in patients with neurological disorders, in particular stroke, and was first described in the literature in 1872. While the exact mechanism can be debated, studies suggest a lesion in the upper brainstem leading to involuntary triggering of the facio-respiratory patterns associated with laughter and crying that involve the motor cortices (Parvizi, et al. 2001) or the cerebellum (Sak, Wilson, 1924). However, with recent studies reporting the prevalence of depression as high as 29% post stroke (Ayerbe, et al, 2013), identifying differences between post-stroke depression and PBA in the emergency setting is crucial for appropriate treatment and disposition. A critical component of patient history with regard to PLC is the lack of inciting stimulus in reports of numerous episodes of pathological crying. This study aims to outline a systematic approach to evaluate and manage patients with PLC in the emergency department (ED).

Case Presentation: The patient was a 74-year-old Caucasian male with no formal PPH and PMH of T2D, HLD, HTN, who was brought by his wife to the ED with complaints of excessive crying and a reported verbalization of suicidal ideation. Upon interview, patient stated that he had been having “crying spells” in excess of emotional stimulus for the prior three months, increasing in severity. He denied neuro-vegetative symptoms of depression. Patient also denied recent stressors. He admitted to a transient ischemic attack five months prior to his presentation. He stated there were no neurological deficits at the time of encounter except for a noted decreased sense of taste. The patient admitted to having suicidal ideations (SI) but without intent, plan, or means. He determined that he had intermittent SI in the context of observing, “Doesn’t everyone think about that sometimes?” He did not report details of his SI as he determined they were passive and vague thoughts of what it would be like to be dead. He denied past or recent suicide attempts or self-injurious behavior. The patient reported he had met with his primary care physician who advised him to go to the ED for further evaluation. The patient and his wife, also in her 70s, reported they thought the ED could prescribe medications and were not seeking hospitalization. His wife stated that the patient had been “crying at the drop of a hat.” She noted that this was not usual for him and denied any recent stressors, or past episodes. She further stated, “I was at my wit’s end and I feel like something is wrong with him.” Patient stated the breaking point was his inability to attend an important engagement due to a dis-inhibited “crying spell” that lasted > 10 minutes. He and his wife reported frustration. The patient also reported, “I can’t take it. Please help me.” Patient affect was depressed, with intermittent “episodes of crying.” We placed him on hold and re-evaluate status.

Method: Patient consent for this study was obtained. A literature search was performed in PubMed and JAMA Psychiatry for articles published on pathological laughing and crying since 1900, using multiple combinations of the search terms, which included the following: post stroke crying syndrome, emotionalism post stroke, involuntary emotional expression, and post stroke neurological disorders. The development of evidence approach and drafting of systemic approach.

Results: On observation, the patient had depressed affect and intermittent episodes of crying without provocation. He repeatedly denied being depressed and denied neuro-vegetative symptoms of depression despite his affect. Psychological review of systems was negative. Vital signs, complete blood count, and electrolytes were within normal limits. Collateral information was obtained and old chart review revealed mild to moderate small-vessel ischemic changes, including a semi-ovale infarct five months prior to presentation. His wife stated she wanted help for his presumed depression. Clinical pathway for the evaluation of emotionalism post stroke in the crisis unit

9th Annual National Update on Behavioral Emergencies Conference (NUBE) in Las Vegas, Nevada (December 12-14, 2018)

includes performing the following: patient intake and triaging —> medical clearance and laboratory work —> patient history, and collateral information —> If patient psychiatrically stable by negative psychological review of systems, consider past medical history for risk factors significant for stroke —> consider ancillary tests to rule out differential diagnoses —> Patient education and reassurance —> Discharge with follow up as a key to diagnosis. Criteria for discharge can include lack of PPH, patient denial of neuro-vegetative depressive symptoms, access to immediate follow-up, social support, lack of social concerns, collateral comfortable with discharge plan and understanding of next steps regarding treatment and follow-up. Citalopram prescribed to patient resulted in decrease in incidence of crying spells. Studies show Citalopram, paroxetine, and sertraline provide >90% efficacy and reduction

in depressive affect and pathological crying in patients (Schiffer et al, 2005).

Conclusion: Post-stroke, neuro-psychiatric pathological crying syndrome is a disorder that results from lesions affecting the pseudo-bulbar aspects of the brain and can go unrecognized. Due diligence on the part of the physician can allow for appropriate disposition, and time and cost-effective steps for proper management of the patient presenting with PLC in the ED. Definitive treatment includes outpatient management with a selective serotonin re-uptake inhibition, in particular Citalopram, paroxetine, and sertraline.

Acknowledgment: I would like to thank Dilys Ngu, MD, for her help in review of this report.